CLINICAL CHART RECORD OF SERVICES BILLED

Client Name: _____ Medicaid Number: _____

Enrolled siblings or other family members? ☐ Yes ☐ No

Primary Diagnosis: _____ ICD9 Code: _____

COMPREHENSIVE						
Date of Service	Place of Service	Comprehensive	Prior Authorization Number	Case Manager's Signature	Claims Status	
					Date Filed	Date Paid

FOLLOW UP								
#	Date of Service	Place of Service	Follow Up		Prior Authorization Number	Case Manager's Signature	Claims Status	
			Face-to-Face	Phone			Filed	Paid
1								
2								
3								
4								
5								
6								
7								

Client Name: _____Client Medicaid Number: _____

FOLLOW UP								
#	Date of Service	Place of Service	Follow Up		Prior Authorization Number	Case Manager's Signature	Claims Status	
			Face-to-Face	Phone			Filed	Paid
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								